**University of Rhode Island**

**Physical Therapy Department**

**HEALTHCARE STUDENT HEALTH SCREEN REQUIREMENTS**

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student D.O.B.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Each of the following health screen requirements needs to be met prior to participant beginning his/her educational experience.

**M.M.R. (MEASLES, MUMPS, RUBELLA)** Complete **ONE** option:

 Option 1): Two (2) doses of MMR

|  |  |
| --- | --- |
| MMR #1 Date:  | MMR #2 Date:  |

Option 2): Proof of two doses Measles, two doses Mumps & one dose of Rubella

|  |  |  |
| --- | --- | --- |
| Measles (Rubeola) | Date #1: | Date #2: |
| Mumps | Date #1: | Date #2: |
| Rubella | Date #1:  |  |

Option 3): Evidence of immunity by documented immune titers

|  |  |  |
| --- | --- | --- |
| Measles Titer Date: | Mumps Titer Date: | Rubella Titer Date: |

**VARICELLA (CHICKEN POX):** Complete **ONE** option:

|  |  |  |
| --- | --- | --- |
| Positive Varicella Titer | Date:  |  |
| Proof of 2 Varivax immunizations | Date:  | Date: |
| Proof of history **documented by MD** | Date:  |  |

**HEPATITIS B VACCINE:**  Complete **ONE** option:

*Hepatitis B vaccines offered and encouraged for all direct patient care providers.*

|  |  |  |  |
| --- | --- | --- | --- |
| Hep B Series Dates | #1 | #2 | #3 |

**OR**

|  |  |
| --- | --- |
| Hepatitis antibody titer | Date:  |

**TETANTUS, DIPHTHERIA and PERTUSSIS/Tdap:**

*One single dose of Tdap is required for all health care workers. Then Tdap is to be given every ten years.*

Tdap Given Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEASONAL INFLUENZA VACCINE:**

The Department of Physical Therapy will require all students to obtain a FLU vaccine every year. Any health care worker may refuse, however, he or she will be required to sign a waiver and wear a surgical mask during each direct patient contact during any declared period in which flu is widespread.

A seasonal vaccine is NOT required at the start of the program as the most current season is over. Each fall semester, students will be notified when the upcoming seasonal vaccine is available and each student is expected to get the vaccine and upload proof of vaccine into the program’s database upon vaccination.

*I have read the above information on the seasonal flu shot and understand the yearly requirement.*

**Student Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TUBERCULOSIS:** *Per 2005 CDC Guidelines, healthcare workers should receive baseline TB testing upon hire (or in this case, admission to the program) regardless of the risk classification of the setting. This is conducted with the Tuberculin Skin Test (TST) or the Blood Assay for M. Tuberculosis (BAMT). If the TST is used for baseline testing, two-step testing is recommended. The URI Department of Physical Therapy requires 2-step baseline TB testing AND annual surveillance testing of all students throughout the program.*

**Every student admitted to the PT program must have two (2) TST’s or one (1) BAMT to start the program. These tests should be completed within 1 month of the start of the program. In addition, the student should be free of the following: symptoms:** productive cough lasting more than three weeks, unexplained fatigue, night sweats, unexplained weight loss, unexplained fever, chills or coughing/spitting up blood.

\*\*\**Two step PPD testing includes two (2) rounds of implantation of the skin test by a Healthcare provider AND reading of each of the tests within 48-72 hours of implantation.*  *It is recommended that the second TST be done 2 weeks after the first TST read.*

**TST (2)**:

Step 1:

|  |  |
| --- | --- |
| Implant Date: | Provider Name:  |
| Read Date:  | Provider Name | Positive\_\_\_\_\_\_\_\_ Negative\_\_\_\_\_\_\_ |

Step 2:

|  |  |
| --- | --- |
| Implant Date: | Provider Name:  |
| Read Date:  | Provider Name | Positive\_\_\_\_\_\_\_\_ Negative\_\_\_\_\_\_\_ |

If **positive**, you are required to have had a negative Chest X- Ray for active TB and evaluated by a physician. If **positive,** have you:

1. Had a chest x-ray? Positive \_\_\_\_\_\_ Negative \_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_

2. Been treated with Anti-Tubercular Drugs: 􏰀 YES 􏰀 NO DATE: \_\_\_\_\_\_\_\_

 Length of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you ever had Blood work? Positive \_\_\_\_\_Negative \_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_

**OR**

**BAMT (QFT-G): Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANNUAL PHYSICAL EXAMINATION:**

The student named above was examined on \_\_\_\_\_\_\_\_\_\_\_\_\_ (date) and found to be in good health for participation in the Physical Therapy Clinical Education program. All immunizations and Tuberculosis screening tests documented on this form have been verified by this provider.

**Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Acceptable documentation of completion of immunizations shall include the day, month, year and type/name of each dose of vaccine administered. The record of such evidence shall be signed by a practitioner (i.e., your health care provider).

The preceding information was taken from:

RULES AND REGULATIONS PERTAINING TO IMMUNIZATION, TESTING, AND HEALTH SCREENING FOR HEALTH CARE WORKERS (R23-17-HCW)
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS- DEPARTMENT OF HEALTH
JULY 2002

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7083.pdf>